POC accepted 3/27/08 BC manager letter to admin

PRINTED: 03/13/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN3619ASC	A. BUILDING _____ B. WING _____	03/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT MARYS O/P SURGERY-GALENA	18653 WEDGE PARKWAY RENO, NV 89511

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 00	INITIAL COMMENTS This Statement of Deficiencies was generated as the result of a State Licensure survey conducted at your facility on 3/5/08, 3/10/08 and 3/11/08. The survey was conducted using Nevada Administrative Code (NAC) 449, Surgical Centers for Ambulatory Patients. Findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions, or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified:	A 00		
A 69	NAC 449.9812 Program for Quality Assurance 2. The program for quality assurance must include, without limitation: (g) Procedures for identifying and addressing any problems or concerns related to the care provided to patients using the medical records of the center and any other sources of data that may be useful to identify previously unrecognized concerns, and for assessing the frequency, severity and sources of suspected problems and concerns. The procedures must include, without limitation, procedures for assessing: (6) The procedures used to control infection. This Regulation is not met as evidenced by: Based on observation, staff interview, and policy review, it was determined that the facility failed to ensure infection control standards were enforced during surgical procedures that required general anesthesia. Findings include:	A 69		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 3/26/08

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A 69	Continued From page 1 Review of the Association of periOperative Registered Nurses (AORN), 2006 Standards, Recommended Practices, and Guidelines revealed that, "anesthesia equipment that comes in contact with mucous membranes should be sterilized or undergo high-level disinfection before use." Laryngoscope blades are categorized as anesthesia equipment that fall into this category. On 3/5/08 at 8:45 AM, in interview, Operating Room (OR) Tech #1 stated that she scrubbed the laryngoscope blades with PowerCon Triple Enzyme Detergent, rinsed them, and then wiped them down with "CaviWipes twice leaving them wet for 30-45 seconds." The blades were left to air dry to completely disinfect. They would then be returned to the doctor for the next use. She stated that she had had no training specific to the disinfection of the blades. On 3/5/08 at 9:00 AM, in interview, OR Tech #2 stated that the procedure to disinfect the laryngoscope blades was to scrub them and wipe them down once with the "CaviWipes as I already scrubbed them to remove any gross material." She indicated that she would leave the blades wet for three minutes on a clean terrycloth towel to air dry and that they would not need to be sterilized. On 3/5/08 at 10:15 AM, in interview, the OR Supervisor stated that the laryngoscope blades just needed to be scrubbed with disinfectant soap, rinsed, and air dried. The OR Supervisor was responsible for supervising the sterilization procedure. On 3/5/08 at 10:30 AM, in interview, the Executive Director (ED) and the Infection Control	A 69		

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A 69	Continued From page 2 coordinator (ICC) stated that the Sterilization Tech had left and the OR Techs were filling in between cases. There was no procedure or policy for the cleaning and sterilization of the laryngoscope blades. The ICC stated that the AORN standards were used by the facility. On 3/5/08 at 11:30 AM the circulating nurse demonstrated how she processed laryngoscope blades following use by the anesthesiologist in the operating room. She stated that she used a Betadine brush and PowerCon Triple Enzyme Detergent to scrub the laryngoscope blade. Review of the CaviWipes label revealed that the disinfectant wipes were not to be used as a terminal sterilant/high-level disinfectant. On 3/5/08 a telephone interview was conducted with the Executive Director. She advised that immediately after the exit with the survey team a new policy was created and implemented that the blades would be sterilized in a Steris. On 3/10/08 it was confirmed that the policy to sterilize the laryngoscope blades was implemented. Severity: 2 Scope: 3	A 69	**A69** **1. Revised policy and procedure regarding laryngoscope reprocessing equipment to current CDC and manufacturers guidelines. (Person responsible- Administrator)** **3/5/2008** **2. Educate OR/decontamination staff to revised policy and procedure. (Person responsible- OR Supervisor)** **3/6/2008** **3. Daily monitoring of anesthesia cart log for sterile laryngoscope equipment as evidenced by OR RN date/time/signature. (Person responsible-OR Supervisor or designee)** **3/24/2008**	
A142	NAC 449.989 Medical Records: Contents The medical record of each patient must be complete, authenticated, accurate and current, and must include the following information: 5. Evidence of any informed consent given for the care of the patient. This Regulation is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure that	A142		

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A142	Continued From page 3 the physician completed the Operative Progress Record in accordance with the facility's requirement for 2 of 12 records. (#11 and #12) Findings include: Review of the patient records revealed a form titled "Operative Progress Record." The form was divided into four sections: Procedure Informed Consent Statement; Blood Transfusion Informed Consent Statement; History and Physical Report Update; and Immediate Post-Operative Note. At the bottom of the form were spaces for the physician to date, time, and sign the form. Patient #11: Review of the record revealed a form that was not completed by the physician except for a physician signature. Patient #12: Review of the record revealed a form that was not completed by the physician except for a physician signature. Interview with the Executive Director on 3/11/08 at 10:20 AM, revealed that the facility required the physicians to complete the form. Severity: 1 Scope: 1	A142	**A142** **1. Re-education of physicians regarding need to fully complete operative progress record. This includes blood loss, findings, Etc. A letter will be distributed to All members of the medical staff. (Person responsible-OR Supervisor, PACU Supervisor, Administrator)**	**3/28/2008**
			2. Daily monitor for medical record completion, to include physician signature, will be done. Cases that fall out will be trended And reported to next Medical Advisory Committee. (Person Responsible-PACU RN's, Business Office)	**3/28/2008**
			3. Medical Advisory Committee to be responsible for compliance and develop appropriate disciplinary action. (Person responsible-Medical Advisory Committee, Medical Director)	**3/24/2008**
A215	NAC 449.9945 Administration/Record of Anesthesia 3. General anesthesia must not be administered to a patient unless a physician has evaluated the patient immediately before surgery to assess and document the risks of administering the anesthesia relative to the surgical procedure to be performed. A patient who received general anesthesia must be evaluated by a physician	A215		

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A215	Continued From page 4 after the patient has recovered from the general anesthesia and before he is discharged from the recovery room. This Regulation is not met as evidenced by: Based on policy review, interview, and record review, it was determined that the facility failed to ensure that a physician evaluated the patient prior to discharge for 9 of 12 records. (#1, #2, #3, #4, #5, #7, #8, #10, and #11) Findings include: A review of the medical staff rules and regulations revealed that all patients were to be evaluated by a physician prior to discharge. Review of the policy titled "Discharge of Patients from the PACU" (post anesthesia care unit) revealed that patients could only be discharged after an assessment by the a physician. The assessment was to occur no more that 30 minutes prior to the actual discharge. An interview with the facility Executive Director on 3/11/08, revealed that a physician was to see the patient within 1/2 hour before discharge. A review of 11 medical records failed to reveal documentation of the physician's evaluation of the patient no more that 30 minutes prior to discharge in the records of Patients #1, #2, #3, #4, #5, #7, #8, #10, and #11. Severity: 1 Scope: 3	A215	**A215** **1. Policy and Procedure will be changed so all patients receiving a general anesthesia must be seen by a physician before discharge of patient from PACU-Recovery Unit. (Person responsible-Administrator)** **3/24/2008** **2 . Daily monitor for medical record completion, to include physician signature, will be done. Cases that fall out will be trended And reported to next Medical Advisory Committee. (Person Responsible-PACU RN's, Business Office)** **3/28/2008** **3. Medical Advisory Committee to be responsible for compliance and develop appropriate disciplinary action. (Person responsible-Medical Advisory Committee, Medical Director)** **3/24/2008**	